COMMUNITY AND HEALTHCARE SYSTEM BARRIERS AND ENABLERS TO UTILIZATION OF FAMILY PLANNING SERVICES IN SCHIEFFLIN TOWN, LIBERIA

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A THESIS SUBMITTED TO THE CUTTINGTON UNIVERSITY SCHOOLS OF GRADUATE AND PROFESSIONAL STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF SCIENCE (M.Sc) IN (MATERNAL CHILD HEALTH)

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DECLARATION BY RESEARCHER

This Master's thesis "Community and Healthcare System Barriers and Enablers to Utilization of Family Planning Services in Schiefflin Town", is my original work and has not been submitted for the award of a degree in any other university or college.

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DEDICATION

So, this research is dedicated firstly, to the Almighty God, who gave me the power, knowledge and understanding to execute this research throughout the storms and stormy time at the Cuttington University Schools of Graduate and Professional Studies Furthermore, I hereby bestow this work to my precious Parents, in persons of Mr. Edwin

Nuahndolay Yarmie and Mrs. Joyce L. Korpuh, my beloved kid (V. Fitzgerald W. Edwins) my brother and sisters, my wife-to-be (Connie P. Innis), for their unflinching support to me during the period of this research.

ABSTRACT

Globally, the percentage of women with an unmet need for family planning decreased from 15.4% in 1990 to 12.3% in 2010. Therefore, the objective study was to identify factor hindering women's access to and utilization to family planning and measures to improve family planning in Schiefflin Town. The result is of benefit to the people of Schiefflin Town, Margibi County, the researcher, the Ministry of Health and Social Welfare, and the WHO, at large. This research used descriptive design, convenient sampling technique, and 76 Family planning users formed part the sample size and target population was all family planning users in Schiefflin. Self-prepared (closed-ended) research questionnaire was used for data collection. The findings showed measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 15 (9%) of the respondents said modern family planning products were available at point of service, while 69 (91%) said no to that. Also, out of the total participants (76), the total of 22 (29%) of the respondents agreed that relationships accept the usage of family planning, while 54 (71%) were in disagreement. In this study, the researcher identified Community and Healthcare System barriers and enablers to Utilization of Family Planning services in Schiefflin Town. This finding

underscored the importance of the further implementation of family planning propagation strategies.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control
CIP	Cost Implementation Plan
CPR	Contraceptive Prevalence Rate
FP/C	Family Planning/Contraceptive
GOL	Government of Liberia
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
I-WISH	Iraq Women Integrated Social and Health Survey
KDHS	Kenya Demographic Health Survey
LDHS	Liberia Demographic Health Survey
LMIC	Low and Middle Income Countries

mCPR Modern Contraceptive Prevalence Rate

SRH Sexual and Reproductive Health

STIs Sexually Transmitted Infections

TFR Total Fertility Rate

UNDESA United Nations Department of Economic and Social Affairs

USAID United States Agency for International Development

WHO World Health Organization

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CHAPTER ONE

1.1 Background of the Study

Contraception is the intentional prevention of conception through various devices, sexual practices, chemicals, drugs, or surgical procedures. According to Alkema *et al.*; (2015), contraception use is increasing worldwide. Globally, contraceptive prevalence has increased from 54.8% in 1990 to 63.3% in 2010, and increasing contraceptive use has decreased the number of maternal deaths by 40% over the past 20 years. Typically, contraceptive prevalence is higher in countries with greater access and availability of contraceptive methods (Mbizvo & Phillips, 2014).

West Africa has one of the most rapidly growing populations and has a high Total Fertility Rates of 5.4 (Haub & Kaneda, 2014). Among the West African Countries, Liberia has a low contraceptive

prevalence rate, a high total fertility rate, and the unmet need is also relatively high; therefore, it is crucial to address the countries which have more significant needs for contraception and family planning programs, to help lower the fertility rate, reduce unmet need, and increase contraceptive prevalence (Haub & Kaneda, 2014).

An additional 30% of maternal deaths could be avoided if the unmet need for contraception is improved (Cleland *et al*. 2012). Contraception non-use is one of the most direct causes of unintended pregnancies in low and middle-income countries (LMIC) (Cleland, 2009). It is estimated that by the year 2015, there will be over 92 million unintended pregnancies worldwide; therefore, researchers must look toward increasing contraceptive use worldwide (Sitruk-Ware *et al*. 2013).

Furthermore, a goal was created in 2012 at the London Summit on Family Planning (“120 by 20”): to reach the number of 120 million women and adolescent girls as users of modern contraception by the year 2020. This goal was developed to help draw more attention to family planning and contraception needs worldwide and hopefully show the areas of opportunity and further research (Brown *et al.* 2014). However, the unmet need for family planning has increased worldwide but remains a problem in some regions, such as Sub-

Saharan Africa. Globally, the percentage of women with an unmet need for family planning decreased from 15.4% in 1990 to 12.3% in 2010 (Alkema *et al*. 2015). The percentage of women with unmet needs is much higher in low and middle-income countries (LMIC).

Among the West African Countries, Liberia has a low contraceptive prevalence rate, a high total fertility rate, and the unmet need for family planning is also relatively high; therefore, it is essential to address the countries which have more significant needs for contraception and family planning programs, to help lower the fertility rate, reduce unmet need, and increase contraceptive prevalence (Cleland, 2011). Liberia also remains among the countries in West Africa that seek to improve their sexual and reproductive health indicators (United States Agency for International Development, 2015).

Family planning and contraceptive programs (FP/C) play a critical role in national and human development. They facilitate regulated population growth that results in social-economic benefits such as decreased poverty levels, enhanced education opportunities and reduced gender inequality (Denton, 2014).

Furthermore, they provide an opportunity for improved maternal and child health, through prevention of sexually transmitted diseases (STIs), unwanted and early pregnancies, and unsafe abortions (Hubacher *et al.* 2008). Cates states that FP/C programs are among the most cost-effective development investments because of their direct influence on improving lives through national security and enhanced financial resources for communities (Cates, 2010).

The United Nations has prioritized increasing and sustaining utilization of FP/C services as one of its eminent strategic investment focus areas in attaining sustainable development goals (SDGs) (Starbird *et al.* 2016). The target is to achieve universal access to sexual and reproductive health (SRH) services, including family planning, information and education by 2030 through investment in various FP/C services programs at national and community levels (Buse & Hawkes, 2015).

The health system consists of various elements involved in healthcare delivery, including human resources for health, service delivery, and supply chain and governance systems (Zulu *et al*. 2015). At community level, the health system can be said to comprise “a set of local actors, relationships, and processes engaged in producing, advocating for, and supporting health in communities, but existing in

relationship to established health structures" (Schneider & Lehmann, 2016). The interaction of community and health systems factors has a critical role to play in as far as the success or failure of a given health program. This paper, therefore, will document community and Health systems barriers and enablers to provision and utilization of FP/C services/methods.

1.2 Statement of the problem

Many women in Sub-Sahara countries know the vital role Family Planning (FP) plays in preventing unwanted pregnancies. Still, they may not know its role in planning and improving the lives and families of the users (International Planned Parenthood Federation [IPPF], 2010). In developing countries, it was estimated in 2012 that 222 million women had an unmet need for FP (Singh & Darroch, 2012). Moreover, reducing the unmet need for FP in SSA and other developing countries would avert more than one million infant deaths and 54 million unwanted pregnancies, which, if not prevented, would result in 21 million inadvertent births, seven million miscarriages, and 26 million abortions of which 15 million would be unsafe (Singh & Darroch, 2012).

Liberia Demographic and Health Survey (LDHS) reported that 33% of women have an unmet need for family planning (21% for spacing and 13% for limiting). Subsequently, Liberia's total fertility rate (TFR) was estimated to be approximately 4.2 children per woman. About 24% of married women are currently using a modern method of contraception. Injectable implants and pills are the most commonly used methods (LDHS 2020).

Condoms reduce the risk of transmission of many Sexually Transmitted Infections (STIs), including Human Immune Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) when used consistently and correctly (WHO & John Hopkins University 2018). To decrease the high burden of maternal mortality and obstetric complication by increasing modern contraceptive utilization, Liberia established a five-year cost implementation plan (CIP) (2018– 2022). The CIP describes priority interventions to increase the modern contraceptive prevalence rate (mCPR) at the national level from 30.7% in 2016 to 39.7% in 2022 (USAID, 2022) Achieving this plan is estimated to avert more than 600,000 unintended pregnancies and nearly 216,000 abortions and will prevent more than 3300 maternal death (GOL, 2018).

Modern contraceptives are a necessary and cost-effective public health intervention to reduce maternal mortality and avert unintended pregnancies, especially in developing countries (Maria & Gomes, 2018; Ahinkorah *et al.* 2021; Sserwanja *et al.* 2021). However, mCPR was low in most of the developing countries, including Liberia (Beson *et al.* 2018; O'Regan & Thompson, 2017). To increase the level of contraceptive use, it is necessary to understand factors that significantly influence contraceptive use. Therefore, assessing the various demographic and reproductive variables contributing to contraceptive use is essential to developing effective family planning programs.

1.3 Research Questions

1. What are factors hindering women's access to and utilization of family planning in Schiefflin Town?

2. What are measures to improve utilization of family planning service in Schiefflin Town?

1.4 Delimitations of the study

This study was done on the Community and Healthcare System Barriers and Enablers to Utilization of Family Planning Service in Schiefflin Town.

1.5 Limitations of the study

The study was limited to finding out measures to increase utilization of Family Planning Services in Schiefflin Town. The study was also limited to finding out factors that hinder women's access to and utilization of family planning services in Schiefflin Town.

1.6 Significance of the study

Despite the remarkable progress in increasing the utilization of family, limited or non-use still exists and it (Utilization) is one of the leading causes of maternal mortality in Liberia. In Schiefflin Town, Margibi County, a study regarding the community and health system barriers and enablers to the utilization of family planning services has been inconsistent. Therefore, this study fetched out information on community and health system barriers and enablers to the utilization of family planning services which is beneficiary the people of Schiefflin Town, Margibi County, the researcher, the ministry of Health and Social Welfare, and the WHO, at large. However, this study serves as a portal of entry to other researchers who are interested in determining Community and Healthcare System Barriers and Enablers to Family Planning Services Utilization in Schiefflin Town, Margibi County, Liberia, to conduct further research.

1.7 Definition of key terms

Community Barriers: factors that negatively influence the utilization of family planning Services in Schiefflin Town

Community Enablers: features that propagate the utilization of family planning services in Schiefflin Town.

Family Planning Service: medical care given to control when and how to have children

HealthCare System Barriers: medical factors that hinder the utilization of family planning services in Schiefflin Town

HealthCare System Enablers: factors that foster the utilization of family planning services in Schiefflin Town

Utilization: making use of Family Planning Services in Schiefflin Town

1.8 Organization of the Study

This work is comprised of just five chapters. The chapter one focuses on the background of the study, statement of the problem, research question, significant of the study, Delimitation, Limitation, Definition of key terms, while chapter two talks about the literature review, which, brought out not less than ten (10) courses. The third

chapter discusses the methodology of the research, which is sometimes called the data-collection phase, and chapter four looked at the data presentation and interpretation. Finally, chapter five is center on the summary, conclusion and recommendations, and References.

CHAPTER TWO: LITERATURE REVIEW

This chapter elaborates on relevant literatures related to Community and Healthcare System barriers and enablers to utilization of family planning services in Schiefflin Town.

2.1 Family Planning Defined

According to the World Health Organization (WHO, 2018), family planning (FP) is the planned use of contraception to decide the timing and the number of children that couples want to have Use of FP helps to avoid unwanted pregnancy, reduce maternal morbidity and mortality by one-third and reduce poverty and hunger (WHO, 2018) by supporting women's economic empowerment and education and their ability to make decisions (Cleland, 2006). Contraceptive prevalence is defined by WHO as the percentage of married or in-union women who are using any method (traditional or modern) of contraception (WHO, 2018).

2.2 Trends of Family Planning

Contraception is the intentional prevention of conception through various devices, sexual practices, chemicals, drugs, or surgical procedures. According to Alkema *et al.*; (2015), contraception use is increasing worldwide. Globally, contraceptive prevalence has increased from 54.8% in 1990 to 63.3% in 2010, and increasing contraceptive use has decreased the number of maternal deaths by 40% over the past 20 years. Typically, contraceptive prevalence is higher in countries with greater access and availability of contraceptive methods (Mbizvo & Phillips, 2014).

West Africa has one of the most rapidly growing populations and has a high TFR of 5.4. Among the West African Countries, Liberia has a low contraceptive prevalence rate, a high total fertility rate, and the unmet need is also relatively high; therefore, it is crucial to address the countries which have more significant needs for contraception and family planning programs, to help lower the fertility rate, reduce unmet need, and increase contraceptive prevalence (Haub & Kaneda, 2014).

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Furthermore, a goal was created in 2012 at the London Summit on Family Planning (“120 by 20”): to reach the number of 120 million women and adolescent girls as users of modern contraception by the year 2020. This goal was developed to help draw more attention to family planning and contraception needs worldwide and hopefully

show the areas of opportunity and further research (Brown *et al.,* 2014). However, the unmet need for family planning has increased worldwide but remains a problem in some regions, such as Sub-Saharan Africa. Globally, the percentage of women with an unmet need for family planning decreased from 15.4% in 1990 to 12.3% in 2010 (Alkema *et.al*, 2015). The percentage of women with unmet needs is much higher in low and middle-income countries (LMIC).

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In Iraq, prevalence of contraceptive use is 58% (44% modern, 14% traditional), which is lower than the global average (63%) and also lower than other countries in the Region such as Jordan (63%) and Tunisia (67%), (World Population Dashboard,2019). The unmet need and the demand satisfied for modern methods are estimated to be 12% and 63% respectively, and the total fertility rate is currently

4.2 children per woman compared with 2.5 globally (World Population Dashboard, 2019).

Furthermore, inequities still exist in FP utilization, with contraceptive prevalence being lower among women in rural areas, women from the poorest quintile or women who have primary or no education; prevalence is higher in women in the Kurdistan region (Iraq Central Statistical Organization, 2018).

Family planning services are intended to be offered free of charge or heavily subsidized in many primary health centers and FP centers in public hospitals (Ebrahim & Muhammed, 2011). In addition, the private sector, such as pharmacies and private clinics, also plays a significant role, especially in providing FP commodities such as oral pills and intrauterine device (IUD) insertion and removal (Ebrahim & Muhammed, 2011). The most commonly used FP method in Iraq is oral pills (50% of all modern methods) followed by IUDs (25%) and injectable (10%), (Iraq Central Statistical Organization, 2011). However, even with the availability of FP services and methods, women may still not use them owing to social, cultural, financial or health care service constraints (Ebrahim & Muhammed, 2011), yet research on these constraints is still very limited in Iraq.

2.3 Family Planning in Sub-Sahara Africa

Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the total fertility rate (TFR), or the average number of birth per woman, was 5.1% more than twice that in South Asia 2.8% (World Bank, 2009). The average contraceptive prevalence rate (22 percent) is less than half that of South Asia (53 percent and less than a 3rd tat of East Asia (77 percent) (World Bank, 2009). Population in the region continues to row at s faster rate (2.3 percent) than in other regions, including bot Asia and Latin American (1.1 percent each) (UNDESA, 2008).

SSA is experiencing rapid demographic growth as a result of fertility rates, meaning that the total population in this part of the world is expected to double by the year 2050 (Bongaarts, 2015; You *et al*. 2015). That means 1.7 billion people living in the region in 34 years' time. There is immediate concern that with such population growth global efforts to reduce poverty and hunger may be stymied, as local food production may not be able to meet population demands (Cleland, 2009). Additionally, the number of women of reproductive age is estimated to increase from 280 million in 2015 to 607 million by 2050, which will also result in an increasing number of unintended pregnancies and births (You *et al*. 2015).

2.4 The Burden of unintended Pregnancy in Sub-Sahara Africa

Without access to FP methods to limited fertility, an average woman could have 15 children over the course of her lifetime (Cleland, 2009). Of the estimated 1.6 million women who are living in the developing world are desire to avoid a pregnancy (i.e., either postpone or stop childbearing altogether), 26 percent of them are not using any form of modern contraceptive (Sin *et al*. 2014). More than half of all pregnancies occur annually in the developing world, and it is estimated that 40 million will result in abortion, 10 million miscarriages, and 30 million will reach live birth.

In the developing world, 81 percent of unintended pregnancies are a result of having an unmet need for contraception (i.e., either using no contraception or a traditional method) (Singh *et al*. 2014). Among the causes of unintended pregnancy, 52 percent are attributed to nonuse of contraceptive method, while 43 percent are attributed to incorrect or inconsistent use of contraceptive method, and just 5 percent of consistent use but method failure (Espey & Ogburn, 2011). The Guttmacher Institute estimated an unintended pregnancy rate of 54 per 1, 000 in the developing world among women ages 15 to 44, compared to 44 per 1,000 in more developed regions of the world (Sedgh, Sin, & Hussain, 2014).

Childbirth in early life is especially dangerous. An estimated 16 million adolescents, ages 15 to 19, give birth each year; in the developing world, the leading cause of death among adolescent females is complications from pregnancy, birth, and unsafe abortion, Among women 25 and younger living in the developing world, maternal sepsis and hemorrhage are common causes of death (Krashin *et al*. 2015). An estimated 33 million adolescents worldwide have an unmet need for contraception (Family Planning, 2020, 2015b).

In 2012, roughly 213 million women living in SSA were of reproductive age (15 to 49 years old). Of this population, 60 percent of women who reported wanting to avoid pregnancy ad an unmet need for modern contraceptive (Darroch & Singh, 2013). An unmet need refers to the situation of women who do not want more children but not using any methods to prevent pregnancy (Cleland & Machiyama, 2015).

Globally, unmet need is highest in SSA (Mbizvo & Philip, 2014; Singh *et al*. 2014). Three of the top four countries with highest unmet need are located in SSA: Liberia, Rwanda, and Uganda (Blumenthal, Voedisch, & Gemzell-Danielsson, 2011). The regional unmet need as

declined by only 6.5 percent from 1994 to 2014 compared to an 11.5 percent decline worldwide (Snow *et al*. 2015).

Unmet need in SSA is highest among less-educated, rural, and poor women (Creanga *et al*. 2011; Mbizvo & Philips, 2014; Sin *et al*. 2014). Research also suggests it may be higher among ethnic minorities, adolescents, and unmarried women (Doyle *et al*. 2012; Vernon *et al*. 2007). Indeed, women in poorest quintiles, who typically reside in rural areas, tend to have between two to four more children than those in the wealthiest quintile who live in urban areas (You *et al*. 2015). Additionally, 73 percent of women living in the poorest quintile have an unmet need for contraceptives, while 46 percent of the wealthiest quintile reports such unmet need (Sin *et al*. 2014).

2.5 Determinants of Family Planning Services Utilization

Understanding men's perceptions and attitudes on family planning is critical, given their influence and decision making role in patriarchal societies (Koffi *et al*. 2018). Traditionally, most family planning programs target women as they are the ones that carry the burden of pregnancy and childbirth. The targeting of women is premised on the assumption that women are more motivated than men to use family planning services and usually have more contacts

with health care providers. However, the women-focused family planning approach tends to overlook gender power dynamics at household levels, where men wield much power and influence at individual, family and societal level, including for contraceptive use or non- use (Tilahun *et al*. 2014).

Studies done in Indonesia and Bangladesh showed that a husband's approval was the most important determinant of contraceptive use (Council, 2016). Furthermore, in situations where male dominance is prevalent, there is a tendency for men to over- rule women on contraception (Duze & Muhammed, 2006). A number of reasons have been linked to men's disapproval of contraceptive use, such as: fear that their wives will be unfaithful and have extramarital affairs; fear of side effects of contraception and perceived ill health associated with it; and losing their role as key decision-makers in the family (Mosha *et al.* 2013).

The covert use of contraceptives by women is a clear indication of power imbalances in sexual and reproductive health matters (Koffi *et al.* 2018). Another crucial aspect of the male perspective on family planning use is spousal communication. Global evidence has illustrated a positive correlation between spousal concordance and

family planning uptake, yet in most patriarchal societies women's voices are unreasonably subdued (Mosha *et al.* 2013).

Studies exploring men's perceptions of family planning have revealed that men in many parts of Africa desire more children than women and marriage has been used by men as a means of reproduction (Abdi *et al.* 2020). A study in Kenya found that men in the North Eastern region (the study site Wajir is in this region) desire three times as many children as men in Nairobi (Mashara, 2016).

The purpose of this study was to explore the perceptions and attitudes of men in two predominantly Muslim counties Wajir and Lamu. Findings of the Kenya Demographic Health Survey (KDHS) show that the total fertility rate (TFR) for Wajir is 7, which is almost double the rate in Lamu at 4.3% and the national average of 3.9% (Kenya National Bureau of statistics, 2014). These two counties have striking differences in contraceptive uptake. Wajir has the lowest contraceptive prevalence rate (CPR) in Kenya at 2% while the CPR in Lamu is 42% (Kenya National Bureau of statistics, 2014).

Apart from the TFRs and CPRs, the two counties have other differences in socio demographic characteristics. Lamu County is a predominantly coastal community of Swahili ethnicity, while Wajir

County is inhabited primarily by pastoralist Somalis. In Lamu, 67% of the population has attained formal education and 13% have secondary education, while in Wajir County only 24% of the population has formal education, and only 4% have reached secondary level (Njonjo, 2013).

2.5.1 Cultural and Historical Context

While the epidemiology of family planning disparities is similar to disparities in other areas of health, with poor and minority women experiencing worse outcomes, the unique historical and cultural context of family planning provides added complexity. Specifically, consideration of disparities in unintended pregnancy and adolescent pregnancy requires consideration of a broad range of social and cultural issues, ranging from sexuality to attitudes towards pregnancy to gender relations to beliefs about contraception and abortion (Stern, 2013).

In addition, while disparities in undesired fertility are the focus of this paper, it is essential to acknowledge that disparities in access to desired fertility have and continue to play an important role in the issue of family planning disparities. The historical relationship between discriminatory beliefs towards poor and minority populations

and some family planning programs and policies, including the nonconsensual sterilization of mentally ill, poor, minority and immigrant women (Stern, 2013) and coercive family planning programs, (Roberts, 2012) affects the relationship between these communities and family planning providers.

In fact, coercion around family planning has never receded completely to the background, as evidenced by controversy over recent programs in which specific populations were paid to use highly effective contraceptive methods (Boonstra *et al*. 2010). Furthermore, decisions about childbearing in the United States occur in a social and economic context in which vast differences in resources to devote to child rearing exist.

2.5.2 Disparities in Family Planning

Outcomes All adverse family planning outcomes - unintended pregnancy, unintended births, abortions and teen pregnancies - occur more commonly among minority and low socioeconomic status (SES) women. While how best to measure unintended pregnancy is debated in the literature, with concern that standard survey questions used may not adequately assess intention, (Barrett, Smith & Wellings, 2010) and with some evidence that this construct may have variable

meanings across cultural and socioeconomic groups, (Kendall *et al*. 2015) the National Survey of Family Growth provides the most commonly used data on this subject.

The most recent of these surveys found that approximately 69% of pregnancies among Black women and 54% among Hispanics were unintended, compared with 40% among White women (Finer & Henshaw, 2011). Having low income and lower levels of education (the most commonly used measures of SES) were also associated with increased risk for unintended pregnancies, with 62% of pregnancies being unintended among those earning <100% of the Federal Poverty Level (FPL), compared to 38% of pregnancies in those earning >200% of the FPL (Mosher *et al*. 2014).

As race/ethnicity and SES are often correlated in the United States, whether these demographic factors are independently related to unintended pregnancies has also been investigated. Race/ethnicity was found to be a predictor of unintended pregnancies even within each income group, and having a lower income was found to be a predictor of unintended pregnancies within each racial/ethnic group (Finer & Henshaw, 2011).

2.5.3 Health Care System

Factors Access to family planning services is limited among vulnerable segments of our population, with important inequities across racial, ethnic and socioeconomic groups, as well as amongst immigrants to the United States. While changes in federal and state legislation, including the introduction of Medicaid expansions and Title X programs, have resulted in improved family planning services for women in low socioeconomic groups, (Gold, 2009) access is still limited, and there remains a large demand for publicly funded contraception.

Approximately half of all sexually active women of reproductive age are estimated to be in need of publicly funded services, and only 50% of them are served under the current system (Gold, 2009). As low SES and minority women are disproportionately uninsured in the U.S, (Ebrahim *et al*. 2008) and women with no insurance coverage are 30% less likely to use prescription contraception, (Culwell & Feinglass, 2007) lack of insurance coverage for contraception is a likely contributor to disparities in unintended pregnancy.

2.6 Availability of Family Planning Services

Family planning services are supposed to be offered in primary health centers and public hospitals free of charge or heavily

subsidized (Ebrahim & Muhammed, 2011). However, FP commodities are sometimes unavailable or are misappropriated from the public to the private sector, and many women have to depend on private pharmacies and clinics to purchase contraception in most areas of the country (Ebrahim & Muhammed, 2011), including the Kurdistan region (Agha & Rasheed, 2007). Currently, only 5% of women have reported public facilities as their source for contraception in I-WISH national survey (Iraq Woman Integrated Social and Health Survey, 2012).

2.7 Accessibility and affordability of family planning services

There are very few studies on the affordability and accessibility of FP services and methods. The Central Statistical Organization in Iraq published a document in 2011 which reported that the affordability and accessibility of commodities accounted for less than 5% of problems among women using contraception (Iraq Central Statistical Organization, 2011). From the search conducted for this report, no published information was found among women not using contraception on FP affordability and services accessibility, including in surveys and field assessments from the Ministry of Health and other organizations about the need among vulnerable groups

(displaced women, those in rural areas) and accessibility for these groups.

2.8 Knowledge and education about family planning services and methods

Although knowledge about FP and its methods is generally good among women (Iraq Central Statistical Organization, 2011), this varies between different governorates (Ebrahim & Muhammed, 2011) and from one method to another; oral pills and IUDs are more commonly known compared with condoms, injectable and other methods (Ismael & Zangana, 2012).

Furthermore, there was a lack of promotional messages such as counseling, leaflets or other methods from health care providers. In the capital, Baghdad, most women said they had not received any information about FP during their visits to the primary health centers (ALmeen & AL-Ayoubi, 2016). Similar findings were reported in Basrah, where only 50% of participants cited health care providers as the source of their contraception information (other sources were family and friends) (Ebrahim & Muhammed, 2011).

Education about correct use was also found to be suboptimal and still needs improvement: some women in Mosul stated that they

did not know how to use contraception as the reason for their unmet need for FP (Al-Jawadi & Al-Bakry, 2010). Furthermore, 20% of unwanted pregnancies were among women who failed to use contraception correctly in Duhok (Agha & Rasheed, 2007) and Mosul (Al-Jawadi & Al-Bakry, 2010), which might also support the lack of accurate information about contraception and its correct use.

2.9 Misconceptions about family planning

Misconceptions about FP and contraception were identified as preventing women from seeking FP services. About 50% of the non-users mentioned health reasons and side-effects such as cancer or infertility for not using any contraception in studies in Basrah (Ebrahim & Muhammed, 2011) and Mosul (Al-Jawadi & Al-Bakry, 2010). Many women said they do not receive enough information about FP from health care providers. Women attending antenatal care in Erbil reported that they had specific questions about contraception but health care providers did not give them sufficient time to address their concerns (Shabila *et al.* 2014).

2.10 Technical capacity and interaction of providers

From the search conducted for this report, no published studies were found looking into provider–client interaction or the technical

knowledge and skills of health care professionals in providing FP services. However, one study in Erbil reported that the average consultation with a doctor took just 2 minutes in the primary health centers, during which the patient received treatment or was referred to hospitals (Tawfik-Shukor & Khoshnaw, 2010).

2.10.1 Choice of method

Although FP services and supplies are meant to be offered in primary health centers, most of them fall short in providing contraception, which means women rely on private clinics and pharmacies to buy contraception commodities (Ebrahim & Muhammed, 2011). The Multiple Indicator Cluster Survey shows that almost all the contraception methods are available in the private sector (Iraq Central Statistical Organization, 2018) but women in one study reported provider bias as they used a specific method due to the provider's preference for one method over the others (Noaman, 2010).

2.10.2 Service delivery

Women can get FP consultation through health facilities but most would have to buy contraception commodities from private pharmacies and clinics due the lack of availability (Ebrahim & Muhammed, 2011). On the other hand, many women in one study said

that they preferred to go to private clinics for the consultation because of the shorter waiting time and better quality of services (Shabila *et al.* 2014).

Promotion of FP was also included in antenatal and postpartum care visits to promote post-delivery contraception (Raoof & Al-Hadithi, 2011). It was reported that only 50% of women received FP counseling during antenatal care in Erbil (Raoof & Al-Hadithi, 2011) but no studies were found on FP counseling during postpartum visits. Furthermore, there are no published reports or information about any guidelines or in-service training for health care providers and no studies on FP counseling during postpartum visits.

2.10.3 Community and individual level

According to the social norms in Iraq, women are still viewed as responsible for raising children, staying at home and taking care of household affairs Iraq Woman Integrated Social and Health Survey, 2012). Furthermore, half of the women in the Iraq Woman Integrated Social and Health (I-WISH) national survey said that men are the key decision-makers in the household. Only 50% of men had discussed the number of children that they wanted to have with their wives Iraq Woman Integrated Social and Health Survey, 2012), and usually the

women preferred to have a fewer children (Iraq Central Statistical Organization, 2011).

Finally, recent conflict and security instability has resulted in more restrictions and has reinforced gender roles within the community, this situation deteriorated as unemployment and poverty became more prevalent and led to high rates of teenage marriage and pregnancy (Cetorelli, 2014).

2.10.4 Husband's and family's position on family planning

The views of the husband on FP also play a vital role in decisions on the use of contraception: many of the women surveyed in one study said they could not use contraception owing to their husband's demand (Nasir, 2011). Women's choice of method of contraception is also influenced by the husband's preference (Tawfik-Shukor & Khoshnaw, 2014). In some instances, women might be denied the right to use contraception by the husband (Ebrahim & Muhammed, 2011) or mother-in-law (Agha & Rasheed, 2007); these are commonly reported causes of hindering utilizing FP services across different backgrounds and different cities in Iraq (Al-Jawadi & Al-Bakry, 2010).

Although no studies on men's involvement in FP in Iraq were identified in the search conducted for this report, the I-WISH survey reported that less than 50% of men have proper knowledge about FP and reproductive health (Iraq Woman Integrated Social and Health Survey, 2012).

2.10.5 Valuing larger families

Families in Iraq value having a high number of children (Iraq Woman Integrated Social and Health Survey, 2012), this was also supported by another national survey where more than half the women said they wanted 3–4 children and 15% said they wanted more than 5 (Iraq Woman Integrated Social and Health Survey, 2012). In addition, many women also reported using FP services for the first time only after having 3 or more children and/or reaching the desired number of children (ALmeen & AL-Ayoubi, 2016).

2.10.6 Religious context

The vast majority of Muslim scholars and leaders have approved the use of FP methods to control the size of the family and advise that women have some time for spacing between pregnancies to maintain good health and well-being (Alnakash, 2008). The I-WISH survey also

revealed that only 2% cited religion as the main reason for not using FP methods (Iraq Woman Integrated Social and Health Survey, 2012).

2.11 Importance of Family Planning in Development

Family planning is immediately relevant to development because it influences the birth rate and population growth rate of country, and therefore as far reaching impacts on economic, social, and environmental well-being in society (Fabic *et al*. 2015; WHO, 2015a).

Sound development policies recognize not only the importance of investments in population health and education, but in FP, programs as well as to provide information and access to modern contraceptive to tat couples can achieve their fertility preferences. In 1999, the centers for disease control and prevention (CDC) named family planning one of the ten greatest public health achievements of the country, for not only health, but also, social and economic benefits for bot woman and family (Tsui *et al*. 2010).

Research from various studies finds FP interventions to be highly cost-effective as they reduce the future health care costs associated with unintended pregnancies and the transmission of sexually transmitted infections (STIs) and IV/AIDS (Tsui *et al*. 2010).

Global data suggest that the increase in mC use within the past six decades in developing countries is responsible for 75 percent of the fertility decline seen there (Cleland *et al*. 2012). In 2008, mC use prevented 25o, 000 maternal deaths secondary to unintended pregnancy. Maternal deaths could be reduced by an additional 30 percent if all the women living in the development world are able to access mC (Cleland *et al*. 2012).

Using FP methods to properly space births could result in a ten percent reduction in child deaths (Cleland, 2009). Seventy five percent of the 8 million unsafe abortions that occurred in 2008 in women ages 15 to 24 could have been prevented ad access to mC available (Kracsin *et al*. 2015).

2.11.1 Maternal and Child Health

In the developing world, gains in FP and SRH have been tremendous over the past few decades; between 1990 and 2013 the maternal mortality rate decreased from 380 to 210 per 100, 000 live births, a 45 percent reduction (Snow *et al*. 2015). There are two primary ways in which family planning reduces maternal and infant mortality: (1) it reduces the rate of unintended pregnancy, and secondary complications from birth, miscarriages, and abortion (2) it

reduces the associated risks of pregnancies that are “too late, too many or too close” (Brown *et al*. 2015, p. 339). Women are considered at higher risk for maternal and child mortality if they become pregnant at a certain age (i.e., younger than 18 or older than 35), have had more than three previous pregnancies, and have had their previous pregnancy less than 24 months prior to the current one (Brown *et al*. 2015).

Essentially, the more births a woman as over her reproductive lifespan puts her at an increasingly higher risk as she ages and her body repeatedly weathers the process of pregnancy and birth. Of the infant, spacing pregnancy by a safe interval (recommended 24 months) decreases te risk of premature birth and low birth weight (Cleland *et al*. 2012). Children born less than two years apart from one another have 60 percent greater chance of dying in infancy than those who are greater than two years apart in age (Cleland *et al*. 2012). Childhood stunting and chronic undernourishment also increases wit sorter birth intervals (Maternal & Child health Integrated Project, 2013).

Improving child survival through safe spacing and reducing risky pregnancy is described as a powerful stimulant for fertility decline, as parents no longer feel the need to have more children to

protect and ensure against potential future child death (Casterline, (2010). Child survival also increases when a woman as a fewer children as the risk of infectious disease transmission decreases, and there is less competition over shared household resourcing including food, healthcare, and nurturing (Brown *et al*. 2015).

CHAPTER THREE: RESEARCH METHODOLOGY

In an outline, this chapter consists of an overview of the chapter, Research Design, Method and materials, research setting of the target population, the sampling Method and sampling, Method of data collection, and Method of Data Analysis and Ethical Considerations.

3.1 Research Design

This study used a descriptive design to examine community and healthcare system barriers and enablers to family planning services utilization in Schiefflin Town.

3.2 Research Population

The target population of the study refers to the people to whom the findings are generalized (Salkind, 2010). Therefore, the target population includes family planning users in Schiefflin Town using a community household listing.

3.3 Sample Size and Sampling Techniques

The sample size is the number of people selected to form part of the study drawn from the targeted population for the research (Salkind, 2010). Consequently, the sample size was 76 respondents in line with the use of the Community household listing done by the researcher. Leaving the researcher with no choice but to include all of those who were part of the household listing as the sample. However, the researcher used convenient sampling technique to sample the respondents

3.4. Data Collection Instrument

The researcher used a self-prepared (closed-ended) research questionnaire to collect data on Community and Healthcare System Barriers and Enablers to Family Planning Services Utilization in Schiefflin Town.

3.6. Data Collection Procedure

The data collection begun with collection of authorization letter from the Dean, School of Health Sciences, Schools of Graduate and Professional Studies, Cuttington University; and taken to all relevant authorities of Schiefflin Town Community for permission to collect data. Following the explanation on the purpose of the research and informed consent, the researcher distributed the questionnaire that was answered in 10-15 minutes. The answered questionnaire was then collected by the researcher for further processing.

3.6 Data Analysis Procedure

The data that was generated from the study was analyzed using SPSS (Statistical Package for Social Sciences; version 25.0), and was be further displayed in frequencies, percentages, tables, and charts. The analysis used descriptive statistics to describe the impact of Community and healthcare System barriers and enablers to utilization of family planning services in Schiefflin Town.

CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION

4.1 Data Presentation and Analysis

The data collected from the study setting are presented in frequency table and bar and pie bbchart as follows:

Table 1: Ages of Participants

Description	Frequency	Percent
15-25 years	33	43
15-25 years	28	37
15-25 years	15	20
Total	76	100

Source: Researcher Field Data

Table 1 shows the ages of participants. Out of the ages of the total respondents (76), 15-25 years cumulated were 33 (43%), and the ages of 26-35 years were 28 (37%), while the age range of 36-45 years

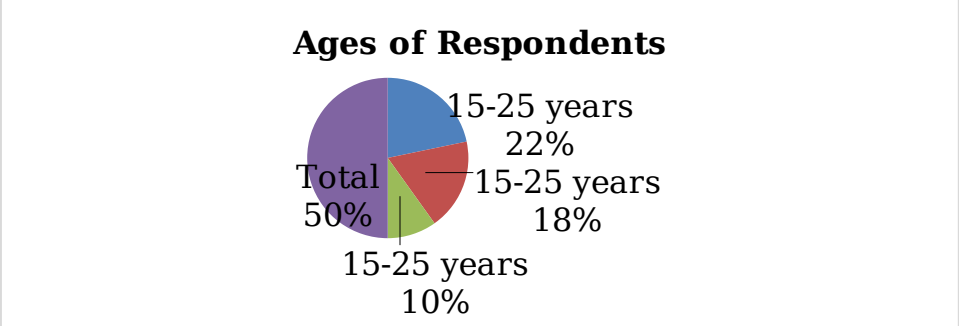


Figure 1: Ages of Respondents

Table 2: Marital status of respondents

Description	Frequency	Percent
Single	50	66
Married	16	21
Others	10	13
Total	76	100

Source: Researcher Field Data

Table 2 shows the marital status of participants. Out of the total participants (76), singles cumulated 50 (66%), and those married

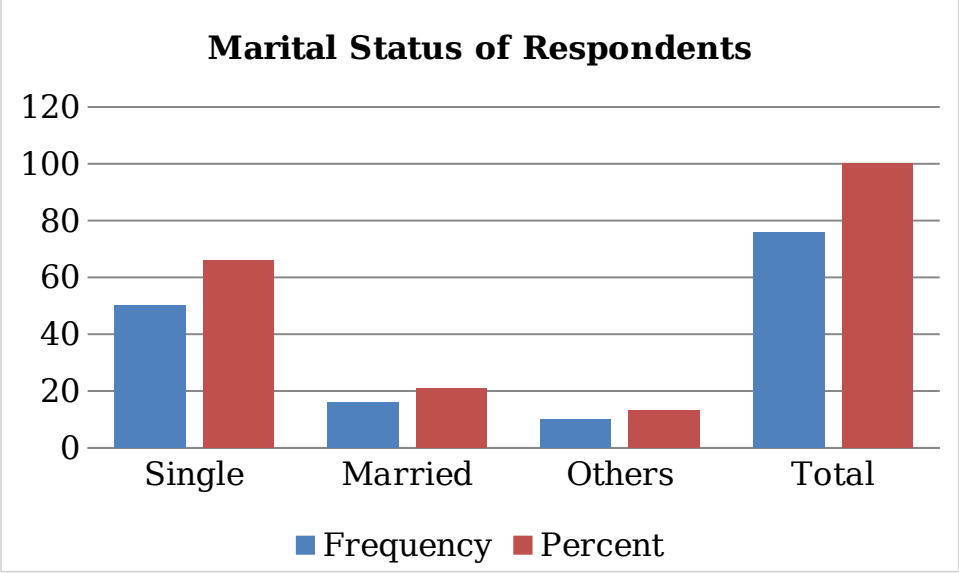


Table 3: Education level of participants

Description	Frequency	Percent
No form of education	15	20
Basic	25	33
Technical	23	30
University	13	17
Total	76	100

Source: Researcher Field Data

Table 3 indicates the education level of participants. Out of the total participants (76), illiterates were 15 (20%), those with basic education were 25 (33%), and those with technical knowledge were 23 (30%), while those with University level education were 13 (17%).

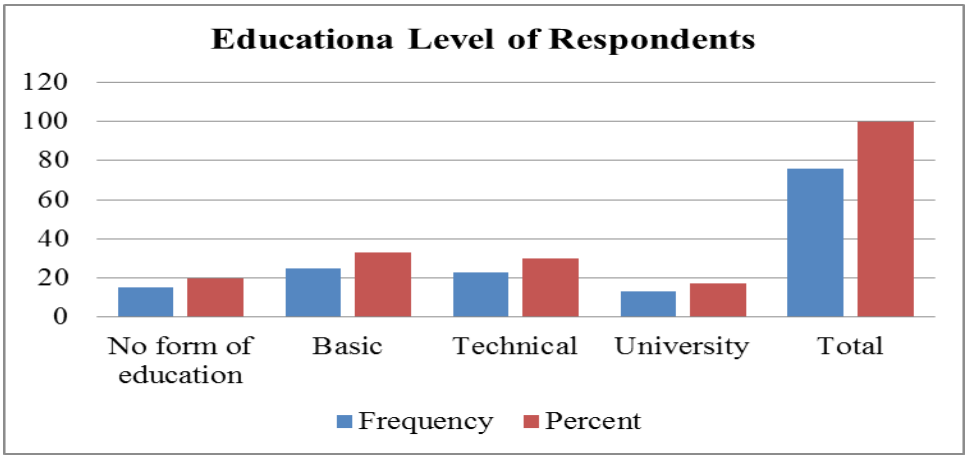


Table 4: Number of children of participants

Description	Frequency	Percent
None	18	24
One	22	29
Two	14	18
> three	22	29

Total	76	100

Source: Researcher Field Data

Table 4 indicates the number of children of participants. Out of the total participants (76), the respondents without children were 18 (24%), those with one child were 22 (29%), and those with two children were 14 (18%), while those with three children and above were also 22 (29%).

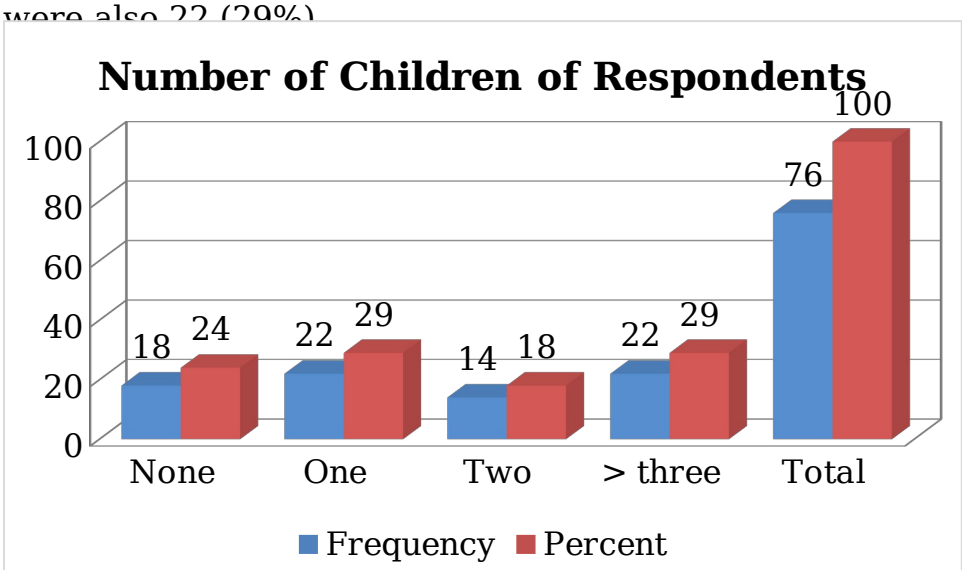


Table 5: religion of respondents

Description	Frequency	Percent
Christians	65	85.5

Muslims	3	3.9
Other	8	10.5
Total	76	100

Source: Researcher Field Data

Table 5 indicates the religion of participants. Out of the total participants (76), Christians were 65 (85.5%), Muslims were 3 (3.9%), and participants who were neither Christians nor Muslims were 8 (10.5%).

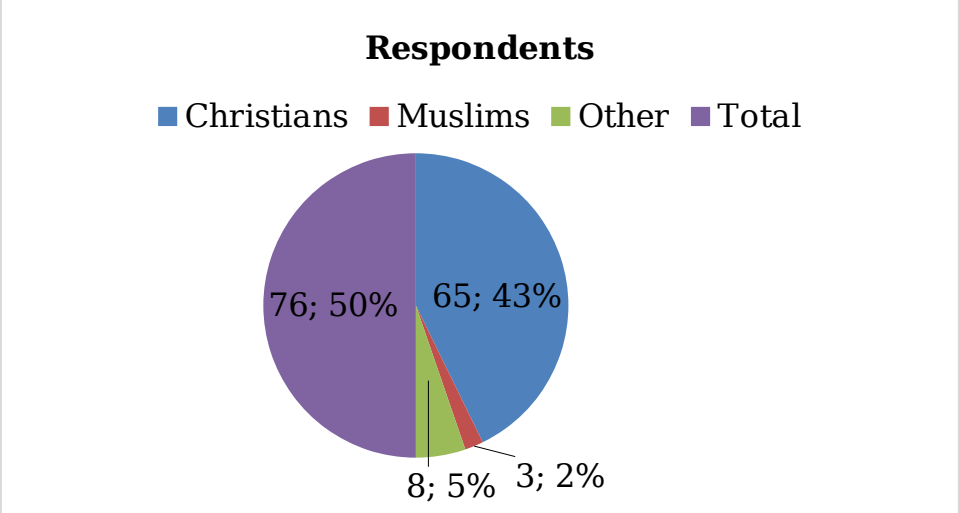


Table 6: Do you feel stopped from using family planning because of the available methods

Response	Frequency	Percent
Yes	33	43
No	43	57
Total	76	100

Source: Researcher Field Data

Table 6 indicates factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 33 (43%) said they were stopped from using family planning because of the available methods, while 43 (57%) said no to that.

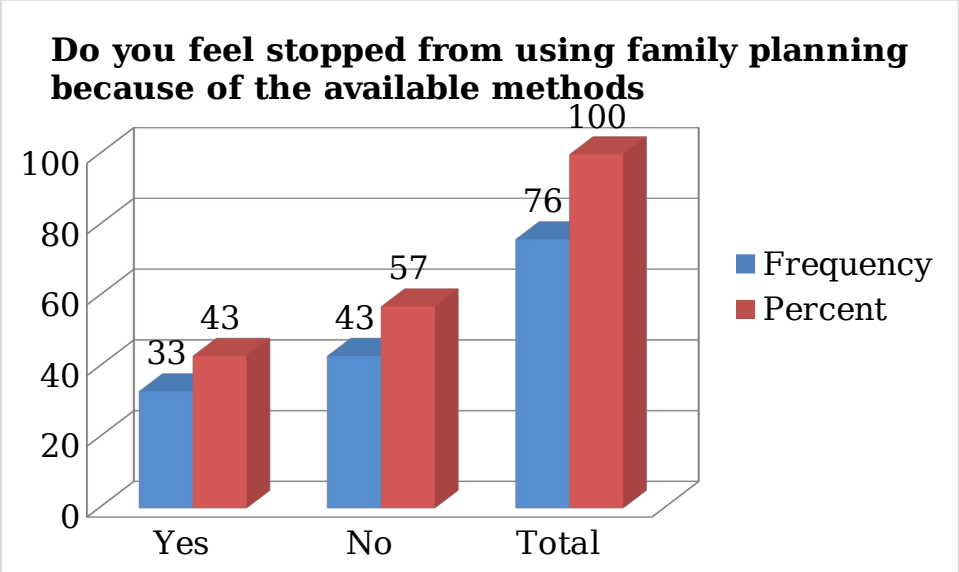


Table 7: Does the way the medicine work stopped you from using it

Response	Frequency	Percent
Yes	7	9
No	69	91
Total	76	100

Source: Researcher Field Data

Table7 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 7 (9%) said they have stopped using family planning because of the way the medicine treated them, while 69 (91%) said no to that.

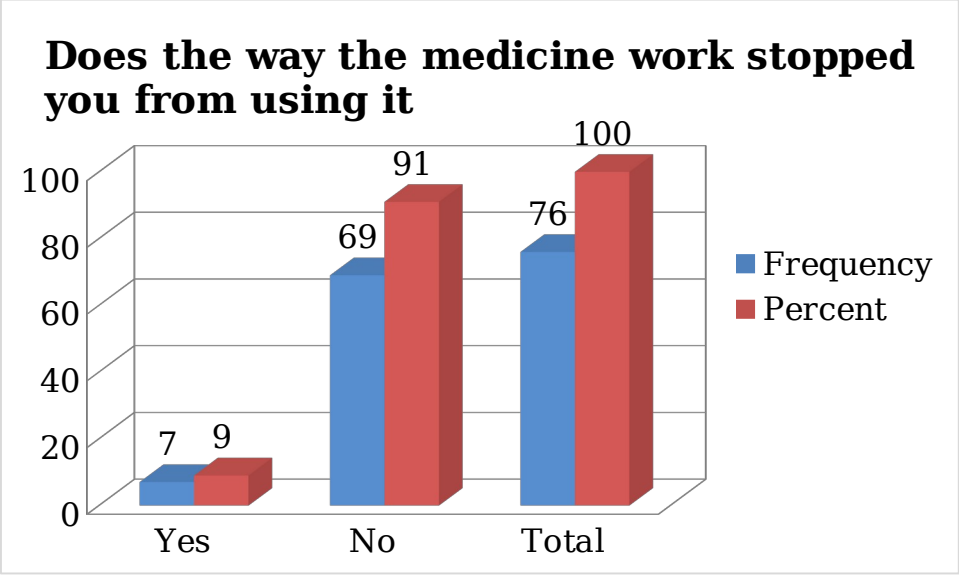


Table 8: Does your religion prohibit from using FP

Response	Frequency	Percent
Yes	22	29
No	54	71
Total	76	100

Source: Researcher Field Data

Table 8 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) said they have stopped using family planning because it is prohibited by their religions, while

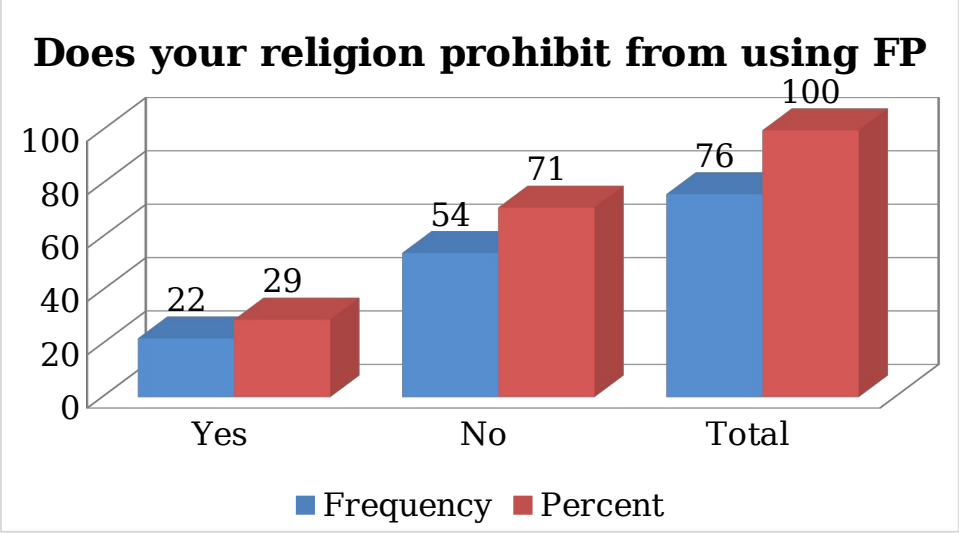


Table 9: Does pressure from peers cause you to use FP

Response	Frequency	Percent
Yes	40	53
No	36	47
Total	76	100

Source: Researcher Field Data

Table 9 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 40 (53%) of the respondents said

they are using family planning because of pressure from peers by their religions, while 36 (47%) said no to that.

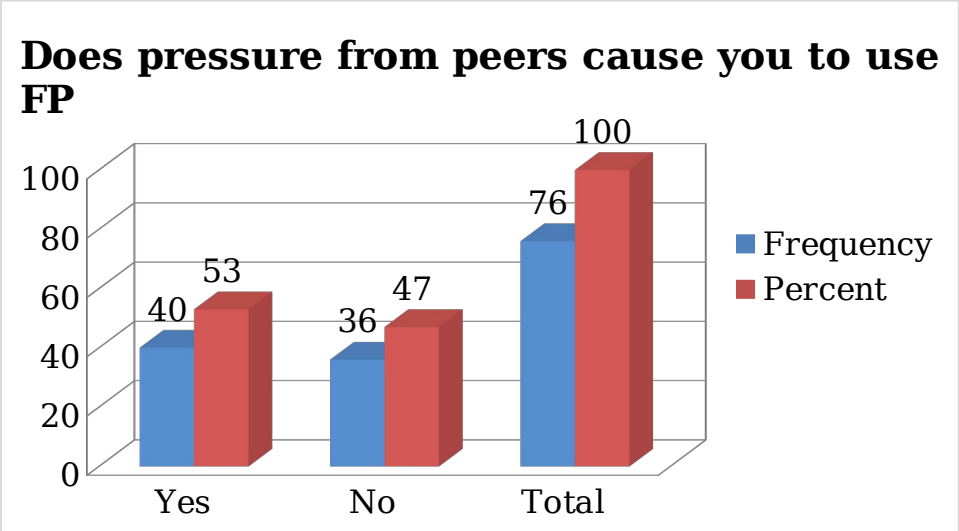


Table 10: Does parental influence affect FP usage

Response	Frequency	Percent
Yes	40	53
No	36	47
Total	76	100

Source: Researcher Field Data

Table10 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 40 (53%) of the respondents said parental influence affects the usage of family planning, while 36 (47%) said no to that.

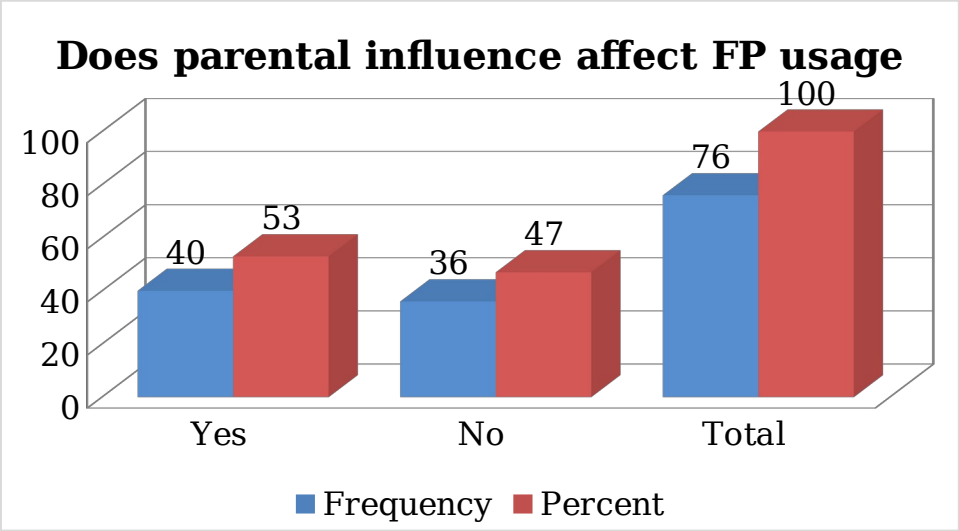


Table 11: Does your relationship accept FP usage

Response	Frequency	Percent
Yes	22	29

No	54	71
Total	76	100

Source: Researcher Field Data

Table 11 illustrates factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) of the respondents said their relationships accept the usage of family planning, while 54 (71%) said no to that.

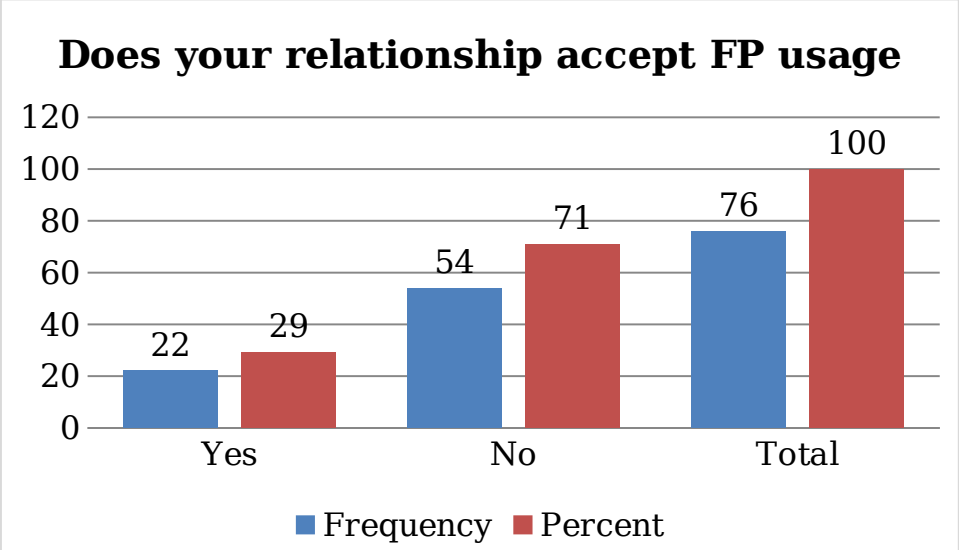


Table 12: Does healthcare provider knowledge matters in FP usage

Response	Frequency	Percent
Yes	22	29
No	54	71
Total	76	100

Source: Researcher Field Data

Table 12 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) of the respondents said healthcare provider knowledge matters to usage of family planning, while 54 (71%) said no to that.

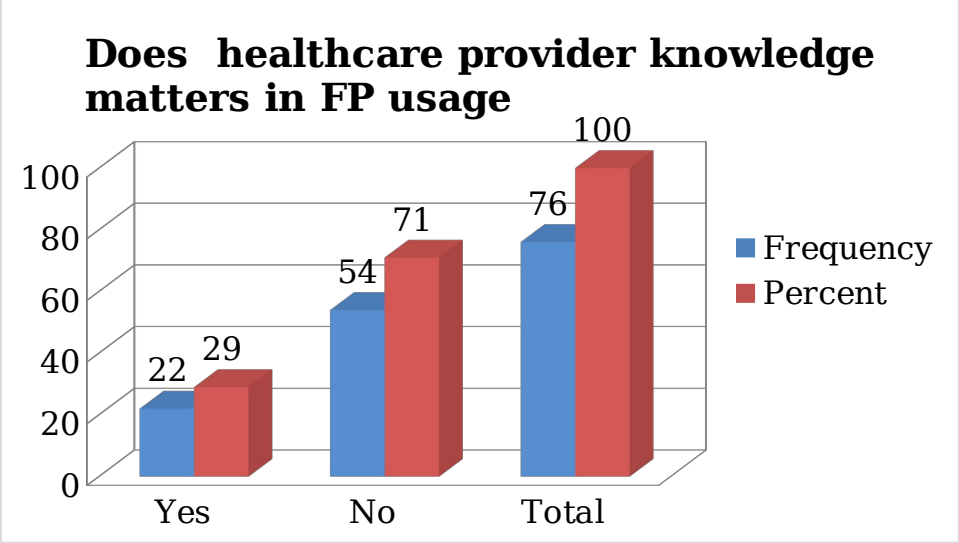


Table 13: Are FP readily accessible

Response	Frequency	Percent
Yes	36	47
No	40	53
Total	76	100

Source: Researcher Field Data

Table 13 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 36 (29%) of the respondents said family planning services are readily accessible to them, while 40 (53%) said no to that.

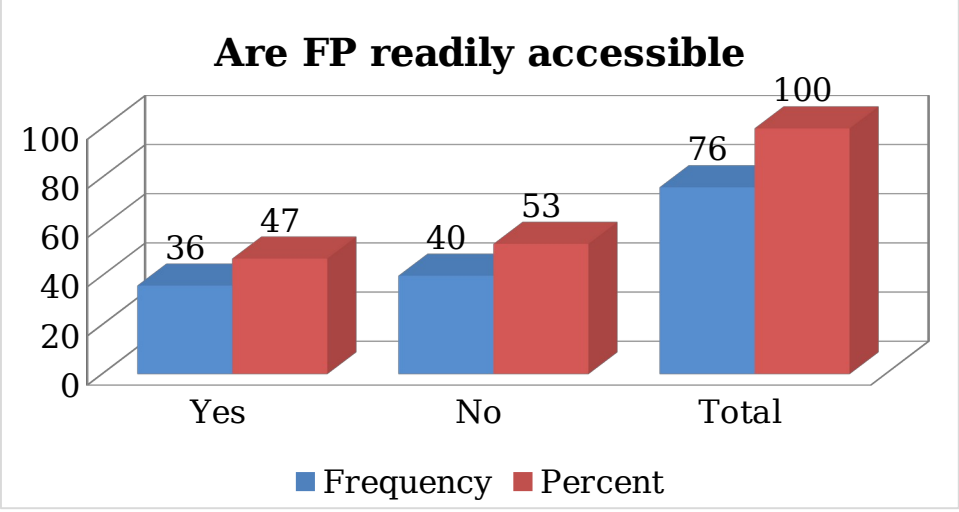


Table 14: Family Planning is a free-of-charge Service

Response	Frequency	Percent
Yes	7	9
No	69	91
Total	76	100

Source: Researcher Field Data

Table 14 demonstrates measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 7(9%) of the respondents said family planning services were charges-free, while 69 (91%) said no to that.

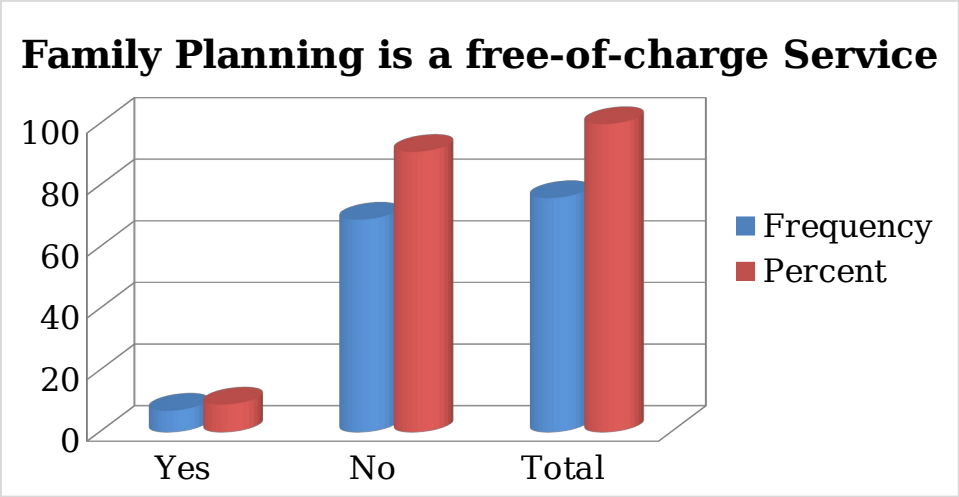


Table 15: Do you have modern FP products as facility

Response	Frequency	Percent
Yes	15	20
No	61	80
Total	76	100

Source: Researcher Field Data

Table 15 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 15 (9%) of the respondents said modern family planning products were available at point of service, while 69 (91%) said no to that.

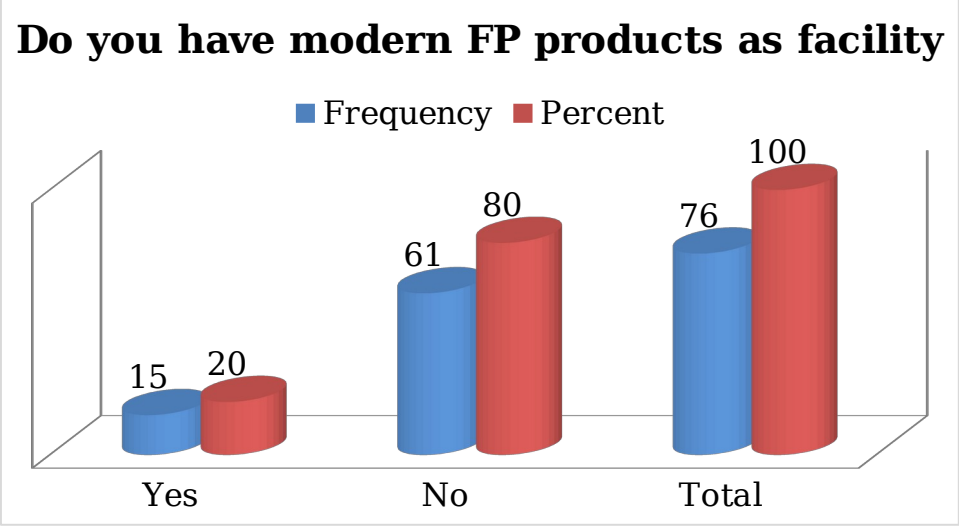


Table 16: Do you have modern FP products at facility

Response	Frequency	Percent
Yes	15	20
No	61	80
Total	76	100

Source: Researcher Field Data

Table 16 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 15 (9%) of the respondents said modern family planning products were

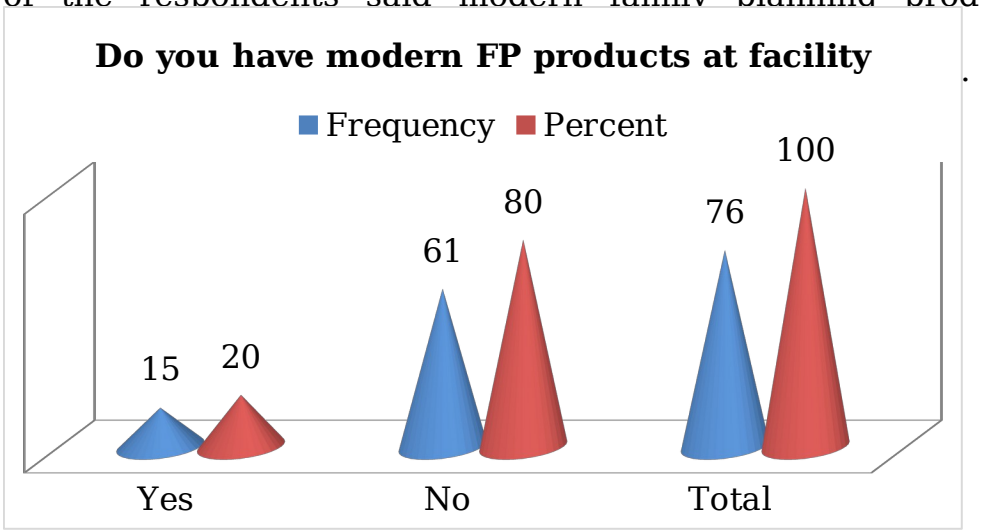
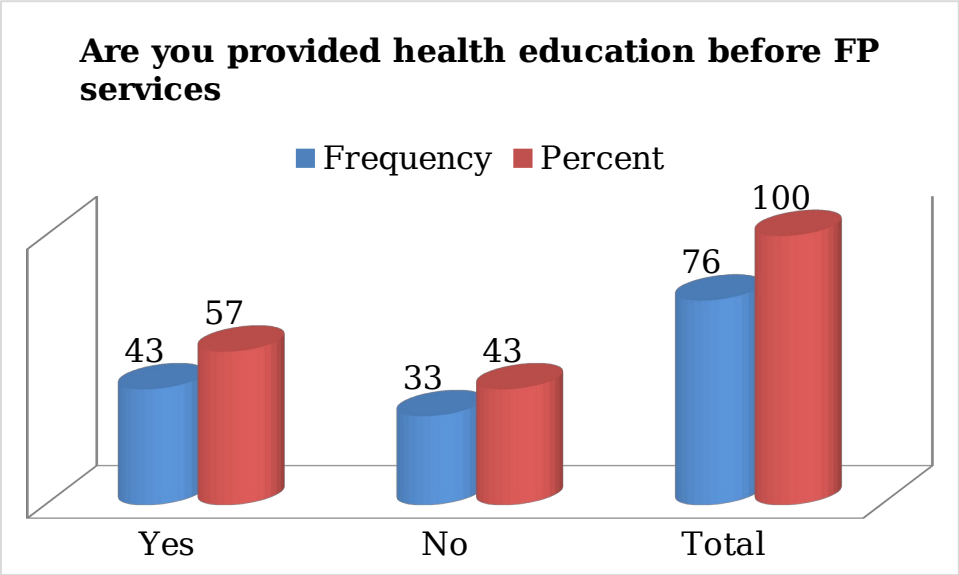


Table 17: Are you provided health education before FP services

Response	Frequency	Percent
Yes	43	57
No	33	43
Total	76	100

Source: Researcher Field Data

Table 17 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 43 (57%) of the respondents said family planning education was provided them before service delivery and 33 (43%) said no to that.



4.2 Findings

Table 1 shows the ages of participants. Out of the ages of the total respondents (76), 15-25 years cumulated were 33 (43%), and the ages of 26-35 years were 28 (37%), while the age range of 36-45 years were 15 (20%).

Table 2 shows the marital status of participants. Out of the total participants (76), singles cumulated 50 (66%), and those married were 16 (21%), while others were 10 (13%).

Table 3 indicates the education level of participants. Out of the total participants (76), illiterates were 15 (20%), those with basic

education were 25 (33%), and those with technical knowledge were 23 (30%), while those with University level education were 13 (17%).

Table 4 indicates the number of children of participants. Out of the total participants (76), the respondents without children were 18 (24%), those with one child were 22 (29%), and those with two children were 14 (18%), while those with three children and above were also 22 (29%).

Table 5 indicates the religion of participants. Out of the total participants (76), Christians were 65 (85.5%), Muslims were 3 (3.9%), and participants who were neither Christians nor Muslims were 8 (10.5%).

Table 6 indicates factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 33 (43%) said they were stopped from using family planning because of the available methods, while 43 (57%) said no to that.

Table7 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 7 (9%) said they have stopped

using family planning because of the way the medicine treated them, while 69 (91%) said no to that.

Table 8 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) said they have stopped using family planning because it is prohibited by their religions, while 54 (71%) said no to that.

Table 9 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 40 (53%) of the respondents said they are using family planning because of pressure from peers by their religions, while 36 (47%) said no to that.

Table10 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 40 (53%) of the respondents said parental influence affects the usage of family planning, while 36 (47%) said no to that.

Table 11 illustrates factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) of the respondents

said their relationships accept the usage of family planning, while 54 (71%) said no to that.

Table 12 shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the total of 22 (29%) of the respondents said healthcare provider knowledge matters to usage of family planning, while 54 (71%) said no to that.

Table 13 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 36 (29%) of the respondents said family planning services are readily accessible to them, while 40 (53%) said no to that.

Table 14 demonstrates measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 7(9%) of the respondents said family planning services were charges-free, while 69 (91%) said no to that.

Table 15 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 15 (9%) of the respondents said modern family planning products were available at point of service, while 69 (91%) said no to that.

Table 16 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 15 (9%) of the respondents said modern family planning products were available at point of service, while 69 (91%) said no to that.

Table 17 shows measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), 43 (57%) of the respondents said family planning education was provided them before service delivery and 33 (43%) said no to that.

4.3 Discussion of the findings

The findings of the study showed the ages of participants. Out of the ages of the total respondents (76), most of the respondents were between the ages of 15-25 years, and the ages of 26-35 years were also in majority, while the ages range of 36-45 years were in fewer amounts.

The study also showed the marital status of participants. Out of the total participants (76), singles were in huge numbers, followed by and those married, while others were the least of them all.

The findings also indicate the education level of participants. Out of the total participants (76), those with basic education were on

the increased followed by those with technical knowledge, while those with University level education and illiterates were in minorities.

The finding indicates the number of children of participants. Of all the total number of participants (76), the respondents with two and three children were in majority, and those with no child and those with two children were the least.

The research also indicates the religion of participants. Obtainable of the total participants (76), Christians were dominant among the respondents, next to Christians were others, and the least of them were Muslims.

The study results showed factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the minority said they were stopped from using family planning because of the available methods, while majority said no to that. According to a study done by USAID, (2015), Liberia also remains among the countries in West Africa that seek to improve their sexual and reproductive health indicators. As such, 33 respondents out of 76 is a significant number to complaint of not having all modern methods which is in concurrence with the study done by USAID in 2015.

The result also shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town according to the findings. Out of the total participants (76), the total of 7 (9%) said they have stopped using family planning because of the way the medicine treated them, while 69 (91%) said no to that.

The findings showed factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), the minority said they have stopped using family planning because it is prohibited by their religions, while vast majority said no to that. A study shows that the vast majority of Muslim scholars and leaders have approved the use of FP methods to control the size of the family and advise that women have some time for spacing between pregnancies to maintain good health and well-being (Alnakash, 2008). The I-WISH survey also revealed that only 2% cited religion as the main reason for not using FP methods (Iraq Woman Integrated Social and Health Survey, 2012). This result differs with the result from I-WISH, 2012).

The result shows factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), most of the respondents said they are using

family planning because of pressure from peers and not promotional messages and jingles, while minority said no to that.

The results showed factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), majority of the respondents said parental influence affects the usage of family planning, while some said no to that.

The study illustrates factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), few of the respondents said their relationships accept the usage of family planning, while most of them said no to that as evident by a study done by Koffi *et al*. (2018), Understanding men's perceptions and attitudes on family planning is critical, given their influence and decision making role in patriarchal societies.

This study showed factors that are hindering Women's access to and utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), less of the respondents said healthcare provider knowledge matters to usage of family planning, while most of the respondents disagreed. This is in agreement with a study done by

ALmeen and AL-Ayoubi, (2016), in the capital, Baghdad which reports that most women said they had not received any information about FP during their visits to the primary health centers.

The findings also showed measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), minority of the respondents said family planning services are readily accessible to them, while majority disagreed to that. This is in total agreement with a study done by The Central Statistical Organization in Iraq published a document in 2011 which reported that the affordability and accessibility of commodities accounted for less than 5% of problems among women using contraception.

The result from this demonstrates measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), hand fold of the respondents said family planning services were charges-free, while vast majority said no to that. This result contributes and concurs with a study done by Ebrahim and Muhammed, (2011), Family planning services are intended to be offered free of charge or heavily subsidized in many primary health centers and FP centers in public hospitals.

This study showed measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), few of the respondents said modern family planning products were available at point of service, while most of the respondents said no to that, and it confirms the finding from a study done by Ebrahim and Mohammed (2011). Family planning services are supposed to be offered in primary health centers and public hospitals free of charge or heavily subsidized (Ebrahim & Muhammed, 2011). However, FP commodities are sometimes unavailable or are misappropriated from the public to the private sector, and many women have to depend on private pharmacies and clinics to purchase contraception in most areas of the country (Ebrahim & Muhammed, 2011).

This research showed measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), also few of the respondents said modern family planning products were available at point of service, while most of the respondents said no to that and this result agrees with a study done by Ebrahim and Muhammed (2011), that although FP services and supplies are meant to be offered in primary health centers, most of them fall short in providing contraception, which means women rely on private clinics and pharmacies to buy contraception commodities.

The findings showed measures to improve utilization of Family Planning Services in Schiefflin Town. Out of the total participants (76), most of the respondents said family planning education was provided them before service delivery and less said no to that and this in contradiction with a study done by Al-Jawadi and Al-Bakry, (2010) in that, education about correct use was also found to be suboptimal and still needs improvement: some women in Mosul stated that they did not know how to use contraception as the reason for their unmet need for FP.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The aim of this study was to investigate Community and Healthcare System Barriers and Enablers to Utilization of Family Planning Services in Schiefflin Town. In order to achieve the objectives (factors hindering Women's access to and utilization of Family Planning Services in Schiefflin Town, and Measures to improve Utilization of Family Planning Services in Schiefflin Town) of this study, the researcher employed a descriptive study design that required review of relevant literatures.

The sample size was obtained using community household listing comprising of 76 participants, leaving the researcher with no choice but to include all of them in the research. The researcher used a closed-ended research questionnaire for data collection activities. The data collection was done by distributing research questionnaire to the respondents in Schiefflin Town.

A letter of consent was obtained from the Dean of the School of Health Sciences, Schools of Graduate and Professional studies, Cuttington University and was taken to the Chairperson/Town chief to gained access to the community or participants. The researcher used SPSS version 25.0 program to input the data that was collected in this

study, for further cleaning, analysis, and presentation in frequency tables.

5.2 Conclusion

In this study, the researcher identified Community and Healthcare System barriers and enablers to Utilization of Family Planning services in Schiefflin Town. This finding underscored the importance of the further implementation of family planning propagation strategies, radio jingles, and leaflets, and the improvement of healthcare services to promote utilization of family planning services among Women in Liberian.

5.3 Recommendations

From the findings of this study, the researcher is moved to recommend the following:

1. Increased health education on family planning and its necessity to the growth and development of Schiefflin Town especially in high schools and town hall or community gatherings.

2. Government should ensure that all family planning services are delivered on a free-of-charge and on effective basis.
3. WHO should have continuous in-service training for Healthcare charged with family planning services in order to have nonusers subscribed to utilization of Family Planning services to enhance reduced unmet needs for family planning.

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Appendix 1: Research Questionnaire

SECTION I: Demography Profile

AGE

15-25 ( )

26-35 ( )

36- 45 ( )

MARITAL STATUS

Single ( )

Married ( )

Others ( )

Education Level

Illiterate ( )

Basic ( )

Technical ( )

University ( )

Number of Children

0 ( )

1 ( )

2 ( )

3> ( )

Religious Affiliation

Christianity ( )

Islam ( )

Other ( )

SECTION II: Factors stopping women's utilization of family planning services

1. Do you feel stopped from using family planning because of the available methods? **Yes ( ) or No ( )**
2. Does the mechanism of action stop you from using family services? **Yes ( ) or No ( )**
3. Does your religious belief prohibit family planning utilization? **Yes ( ) or No ( )**
4. Are you afraid of using family planning because of what people been telling you? **Yes ( ) or No ( )**
5. Is it parental influence that is stopping you from using family planning? **Yes ( ) or No ( )**
6. Does your relationship accept usage of family planning? **Yes ( ) or No ( )**
7. Does knowledge of family planning service provider matters in family planning? **Yes ( ) or No ( )**

SECTION III: measure to improve usage of family planning services

1. Are family planning services accessible to you? **Yes ( ) or No ( )**
2. Is family planning a government or free-of-charge service? **Yes ( ) or No ( )**
3. Are there all modern methods of family planning available to you? **Yes ( ) or No ( )**
4. Do you hear jingles on family planning counseling, leaflets, or other methods from service providers, on family planning services? **Yes ( ) or No ( )**

5 Are there skilled providers of family planning services? **Yes ( ) or No ( )**

Appendix II: Inform Consent

Greetings!

I am Eddie T. Yarmie, a student of the Cuttington University Schools of Graduate and Professional Studies, and I am currently undertaking a research project on Community and Healthcare System Barriers and Enablers to Utilization of Family Planning Services in Schiefflin Town, Margibi County. In relations to this, may I request you to provide answers to the attached research questions according to your understanding? Rest assured that all information provided will be treated with confidentiality, and straightly use for academic purpose only.

Please do not hesitate to call me for any inquiry on clarity while going through the questions, and your participation is free; so, you may withdraw from the process at any given point.

Thanks for your willingness to forming part of this study

Signed: _____ Date: _____

Eddie T. Yarmie

Student

Contact: 0770460101